

5621

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>74 House de Grace</u>		<u>7 wks</u>		TOWN <u>Port Deposit</u>		<u>07x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 St. Bernard Mem. Hosp.</u>				STREET ADDRESS <u>R.D.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Caroline</u> (First) <u>Abrahams</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 5</u> 19 <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 27, 1869</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>L. W. Abrahams</u>				14. MOTHER'S MAIDEN NAME <u>MARY J. BARTLETT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John J. Abrahams, Jr., Port Deposit Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>4 yrs -</u>			
1741 IMMEDIATE CAUSE (A) <u>Carcinoma of Uterus</u>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19, 55</u> , to <u>June 5, 55</u> , that I last saw the deceased alive on <u>June 5, 19, 55</u> , and that death occurred at <u>2:33 PM</u> , from <u>the</u> causes and on the date stated above.							
SIGNATURE <u>G. J. Benson</u> M.D.				ADDRESS (Street, city, town, state) <u>Port Deposit, Md.</u> DATE SIGNED <u>6-5-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, R.D., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>June 7-1955</u>		<u>A. L. Lewis m.d.</u>		<u>Leea. Pattersonson, Perryville Md.</u>			

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

# CERTIFICATE OF DEATH

1891

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF OTHER

16. SIGNATURE OF

17. SIGNATURE OF

18. SIGNATURE OF

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20. SIGNATURE OF

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BARTLETT

BUREAU V. S.

JUN 9 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05631

5622

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hanford</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Cecil</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>07X-2</u>	
CITY OR TOWN <u>Harrods Grace</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>Rt #1</u>		(If rural give location) <u>✓</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hanford Memorial Hospital</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Boyd Daniel Thomas Ashlin</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June 9 1955</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Newborn</u>		<b>8. DATE OF BIRTH</b> <u>June 9-1955</u>	
<b>9. AGE last birthday</b> <u>—</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		<b>11. BIRTHPLACE (State or foreign country)</b> <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Thomas Ashlin</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Wheatley</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital Records -</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>776X IMMEDIATE CAUSE (A)</b> <u>Prematurity 6 mos.</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>6/9</u>, 19<u>55</u>, to <u>6/9</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6/9</u>, 19<u>55</u>, and that death occurred at <u>8:40</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Paul Taylor</u> M.D.				<b>ADDRESS (Street, city, town, state)</b> <u>Harrods Grace, Md.</u>			
<b>23. <del>USUAL</del> CREMATION, <del>REMOVAL</del> (SPECIFY)</b>				<b>DATE THEREOF</b> <u>10 JUNE 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>HANFORD MEMORIAL HOSPITAL</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>REGISTRAR'S SIGNATURE</b> <u>G. L. Lewis M.D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harry R. Tully Administrator</u>	
<b>DATE</b> <u>June 13-55</u>				<b>ADDRESS</b>			

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JUN 15 1955

RECEIVED

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-m.u.

1726. # 2648

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05632

5623

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>HAURE DE GRACE</u>		18 DAYS		TOWN <u>BEL AIR</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>HARFORD MEMORIAL HOSP.</u>				RD #2 1			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>William</u> (Middle) <u>Banks</u> (Last)				Month <u>6</u> Day <u>21</u> Year <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	C	WIDOWED	12-28-1884	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
FARMER		FARM		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE BANKS				JULIA COOPER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		212-16-0400		Mrs. Hannah B. Johnson - Bel Air, Md. P.F.D.#2			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
177X IMMEDIATE CAUSE (A) <u>Uremia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca. of Prostate</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myelophthisic Anemia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1955</u> , to <u>June 21, 1955</u> , that I last saw the deceased alive on <u>June 21, 1955</u> , and that death occurred at <u>3:28</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u> M.D. <u>569 Revolution St. Harford, Md.</u>				DATE SIGNED <u>6/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6-24-55		Arling Cemetery		W. Churchville, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
June 22-55		G. L. Lewis M.D.		Atelia J. Bullock-Harford, Md.			



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX Male		RACE White	
DATE OF DEATH June 24, 1955		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

THIS CERTIFICATE IS VALID ONLY WHEN FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS NOT VALID FOR ANY OTHER PURPOSE.

RECEIVED  
 JUN 24 1955  
 BUREAU V. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5640

05633  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits write RURAL OR and give nearest town) TOWN <u>Whiteford</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Whiteford</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>State Ridge Rd</u>				STREET ADDRESS (If rural, give location) <u>State Ridge Rd.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>CLYDE</u> <u>ZALE</u> <u>BENNINGTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June</u> <u>13</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify): <u>None</u>		8. DATE OF BIRTH: <u>May 30, 1902</u>	
9. AGE last birthday: <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Frederick Ernest Bennington</u>				14. MOTHER'S MAIDEN NAME: <u>Florence Irene Tarbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>unk.</u>		17. INFORMANT & ADDRESS: <u>Brother - Walter Bennington</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>420.1 Immediate cause (a) <u>Coronary Occlusion</u> DUE TO</p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c) _____</p>							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Alcoholism</u>							
19a. DATE OF OPERATION: <u>6-15-55</u>				19b. MAJOR FINDING OF OPERATION: _____			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY _____		21c. (City or town) _____ (County) _____ (State) _____			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Philip W. Heuman</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/13/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>6-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>	
DATE REC'D BY LOCAL REG. <u>6-15-55</u>		REGISTRAR'S SIGNATURE <u>Maxilla Howard</u>		24. FUNERAL DIRECTOR <u>JOHN H. HARKINS, DELTA, PA.</u>		ADDRESS _____	

BUREAU V. S.

JUN 17 1955

RECEIVED



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## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5641

## CERTIFICATE OF DEATH

05634

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED (see birth cert.)</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Penna.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen Pr Gr</u>		<u>1 day</u>		TOWN <u>Aberdeen Braddock</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USA Hospital</u>				STREET ADDRESS (If rural give location)			
<u>50</u> <u>Aberdeen Pr Gr, Md</u>				<u>43 Taft St</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Michaël</u> <u>BIASIK</u>				<u>June</u> <u>11</u> <u>1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>10 June 1955</u>	<u>0</u> yrs.	Months Days	Hours Min.	<u>17</u> <u>5</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Stephen Biasik</u>				<u>Dorothy Radziwon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>W.H. MACKIE, Capt, MSC, AOD, USAH, APG, Md</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>776x</u> IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>None</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>NONE</u>		<u>NA</u>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<u>NA</u>		<u>NA</u>		<u>NA</u>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>NA</u>		<u>NA</u>		<u>NA</u>			
<b>22. I hereby certify that I attended the deceased from <u>8:15am 11 Jun 55</u>, to <u>1:55pm 11 Jun 55</u>, that I last saw the deceased alive on <u>11 Jun 1955</u>, and that death occurred at <u>1:55p.m.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Thomas C Lipscomb, Capt MC, M.D. USA Hospital, Aberdeen Pr Gr, Md</u>				<u>11 Jun 55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Removal</u>		<u>6/13/55</u>		<u>Braddock Ath. Cemetery</u>		<u>Braddock, Pennsylvania</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>June 13-55</u>		<u>Willie G. Perry</u>		<u>John G. Barving</u>		<u>Aberdeen Md.</u>	

2065265382

# 7811 CERTIFICATE OF DEATH

Form 100-10-10-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

18. SIGNATURE OF

19. SIGNATURE OF

20. SIGNATURE OF

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33. SIGNATURE OF

34. SIGNATURE OF

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

17. SIGNATURE OF

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1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

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1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF CHURCH

16. SIGNATURE OF OTHER

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MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. 1

JUN 16 1955

RECEIVED

05635 181

5642

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Rural-Abundant</i>		<i>2.5 yrs</i>		TOWN <i>Rural-Abundant</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Grace Md. R.D. 1</i>				STREET ADDRESS (If rural, give location) <i>Harford Grace R.D. #1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Harvey Haines Borden</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>June 21 1955</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Oct. 17, 1867</i>	
				9. AGE last birthday <i>87</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hardware Store</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Borden</i>				14. MOTHER'S MAIDEN NAME <i>Archie M. Haines</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>John M. Borden Harford Grace Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
612X IMMEDIATE CAUSE (A) <i>Asepsia</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Post operative</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>June 3, 1955</i>		19b. MAJOR FINDINGS OF OPERATION <i>Trans urethral operation</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-21, 1955</i> to <i>6-21, 1955</i> that I last saw the deceased alive on <i>6-21, 1955</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>John M. Borden</i>				ADDRESS (Street, city, town, state) <i>Harford Grace Md.</i>		DATE SIGNED <i>6-22-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>6-23-55</i>		NAME OF CEMETERY OR CREMATORY <i>ROSEBANK CEM.</i>		LOCATION (City, town, or county) (State) <i>CECIL Co MD</i>	
24. REC'D BY REGISTRAR <i>June 24, 1955</i>		REGISTRAR'S SIGNATURE <i>William R. Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Madison Mitchell</i>		ADDRESS <i>Harford Grace Md.</i>	

# CERTIFICATE OF DEATH

Reg. No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Date of birth

4. Age

5. Race

6. Place of birth

7. Date of death

8. Time of death

9. Cause of death (Print or write full name)

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Date of registration

14. Time of registration

15. Cause of death (Print or write full name)

16. Place of death

17. Signature of physician

18. Signature of registrar

19. Date of registration

20. Time of registration

21. Cause of death (Print or write full name)

22. Place of death

23. Signature of physician

24. Signature of registrar

25. Date of registration

26. Time of registration

27. Cause of death (Print or write full name)

28. Place of death

29. Signature of physician

30. Signature of registrar

31. Date of registration

32. Time of registration

33. Cause of death (Print or write full name)

34. Place of death

35. Signature of physician

36. Signature of registrar

37. Date of registration

38. Time of registration

39. Cause of death (Print or write full name)

40. Place of death

41. Signature of physician

42. Signature of registrar

43. Date of registration

44. Time of registration

45. Cause of death (Print or write full name)

46. Place of death

47. Signature of physician

48. Signature of registrar

49. Date of registration

50. Time of registration

51. Cause of death (Print or write full name)

52. Place of death

53. Signature of physician

54. Signature of registrar

55. Date of registration

56. Time of registration

57. Cause of death (Print or write full name)

58. Place of death

59. Signature of physician

60. Signature of registrar

61. Date of registration

62. Time of registration

63. Cause of death (Print or write full name)

64. Place of death

65. Signature of physician

66. Signature of registrar

67. Date of registration

68. Time of registration

69. Cause of death (Print or write full name)

70. Place of death

71. Signature of physician

72. Signature of registrar

73. Date of registration

74. Time of registration

75. Cause of death (Print or write full name)

76. Place of death

77. Signature of physician

78. Signature of registrar

79. Date of registration

80. Time of registration

81. Cause of death (Print or write full name)

82. Place of death

83. Signature of physician

84. Signature of registrar

85. Date of registration

86. Time of registration

87. Cause of death (Print or write full name)

88. Place of death

89. Signature of physician

90. Signature of registrar

91. Date of registration

92. Time of registration

93. Cause of death (Print or write full name)

94. Place of death

95. Signature of physician

96. Signature of registrar

97. Date of registration

98. Time of registration

99. Cause of death (Print or write full name)

100. Place of death

101. Signature of physician

102. Signature of registrar

103. Date of registration

104. Time of registration

105. Cause of death (Print or write full name)

106. Place of death

107. Signature of physician

108. Signature of registrar

109. Date of registration

110. Time of registration

111. Cause of death (Print or write full name)

112. Place of death

113. Signature of physician

114. Signature of registrar

115. Date of registration

116. Time of registration

117. Cause of death (Print or write full name)

118. Place of death

119. Signature of physician

120. Signature of registrar

121. Date of registration

122. Time of registration

123. Cause of death (Print or write full name)

124. Place of death

125. Signature of physician

126. Signature of registrar

127. Date of registration

128. Time of registration

129. Cause of death (Print or write full name)

130. Place of death

131. Signature of physician

132. Signature of registrar

133. Date of registration

134. Time of registration

135. Cause of death (Print or write full name)

136. Place of death

137. Signature of physician

138. Signature of registrar

139. Date of registration

140. Time of registration

141. Cause of death (Print or write full name)

142. Place of death

143. Signature of physician

144. Signature of registrar

145. Date of registration

146. Time of registration

147. Cause of death (Print or write full name)

148. Place of death

149. Signature of physician

150. Signature of registrar

151. Date of registration

152. Time of registration

153. Cause of death (Print or write full name)

154. Place of death

155. Signature of physician

156. Signature of registrar

157. Date of registration

158. Time of registration

159. Cause of death (Print or write full name)

160. Place of death

161. Signature of physician

162. Signature of registrar

163. Date of registration

164. Time of registration

165. Cause of death (Print or write full name)

166. Place of death

167. Signature of physician

168. Signature of registrar

169. Date of registration

170. Time of registration

171. Cause of death (Print or write full name)

172. Place of death

173. Signature of physician

174. Signature of registrar

175. Date of registration

176. Time of registration

177. Cause of death (Print or write full name)

178. Place of death

179. Signature of physician

180. Signature of registrar

181. Date of registration

182. Time of registration

183. Cause of death (Print or write full name)

184. Place of death

185. Signature of physician

186. Signature of registrar

187. Date of registration

188. Time of registration

189. Cause of death (Print or write full name)

190. Place of death

191. Signature of physician

192. Signature of registrar

193. Date of registration

194. Time of registration

195. Cause of death (Print or write full name)

196. Place of death

197. Signature of physician

198. Signature of registrar

199. Date of registration

200. Time of registration

201. Cause of death (Print or write full name)

202. Place of death

203. Signature of physician

204. Signature of registrar

205. Date of registration

206. Time of registration

207. Cause of death (Print or write full name)

208. Place of death

209. Signature of physician

210. Signature of registrar

BUREAU V. S.

JUN 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. No. **05636**No. **182**

<b>I. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <b>Harford</b>		MARYLAND		STATE <b>MD</b>		COUNTY <b>Harford</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>322 BELAIR MD</b>		LENGTH OF STAY (in this place) <b>2 year</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>32 BELAIR</b>		STREET ADDRESS (If rural, give location) <b>1</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
<b>3. NAME OF DECEASED:</b> (First) <b>Fenley</b> (Middle) <b>Thompson</b> (Last) <b>Brewer</b>				<b>4. DATE OF DEATH</b> (Month) <b>June</b> (Day) <b>25</b> (Year) <b>1955</b>			
<b>5. SEX:</b> <b>M</b>	<b>6. COLOR OR RACE:</b> <b>W</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <b>Married</b>	<b>8. DATE OF BIRTH:</b> <b>July 18-1920</b>	<b>9. AGE last birthday:</b> <b>34</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>Days</b> <b>Hours</b> <b>Min.</b>		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <b>Road Truck</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <b>labor</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <b>Fox, Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME:</b> <b>Roy Brewer</b>				<b>14. MOTHER'S MAIDEN NAME:</b> <b>L Brewer</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes</b>		<b>16. SOCIAL SECURITY No.:</b> <b>223-24-0287</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <b>Leona Honaker Brewer</b>			
<b>(If Yes, give war or dates of service)</b> <b>World War 2</b>							
<b>18. MEDICAL CERTIFICATION</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
<b>812X</b> <b>Immediate cause</b> (a) <b>Fracture skull</b> <b>DUE TO</b>							
<b>Antecedent cause(s)</b> (b) <b>DUE TO</b> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Compound fracture both bones both legs</b>							
<b>19a. DATE OF OPERATION:</b> <b>0</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>					<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)</b> <b>State 1</b>		<b>21c. (City or town) (County) (State)</b> <b>Bel Air Harford MD</b>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <b>6/25/55 11:30 P.M.</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Auto accident - auto-pedestrian type</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <b>Lerald C Palmer</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>6/26/55</b> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>					
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <b>Removal</b>		<b>DATE THEREOF</b> <b>June 28/55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt Zion Methodist</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Fountain Green Harford MD</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>6-27/56</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Prueella Fownd</b>		<b>24. FUNERAL DIRECTOR</b> <b>Joseph T. Fols Bel Air Md</b> <b>ADDRESS</b>			

BUREAU V. S.

JUN 30 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5626

## CERTIFICATE OF DEATH

05637

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>BEL AIR</u> TOWN <u>BEL AIR</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>HARFORD</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u> OR TOWN <u>BEL AIR</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD II</u>		STREET ADDRESS <u>RD II</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>ADA</u> (First) <u>MAE</u> (Middle) <u>COX</u> (Last)		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan 29 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>NEBO, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>William J. GUILLION</u>		14. MOTHER'S MAIDEN NAME <u>MARY Lee TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>ROSALIE LAWSON, Bel Air, Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) <u>CORONARY OCCLUSION</u> ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Diabetes MELLITUS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 28, 1955</u> , to <u>June 20, 1955</u> , that I last saw the deceased alive on <u>June 20, 1955</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Alex. Sandeechi M.D.</u>		DATE SIGNED <u>6-20-55</u>	
ADDRESS (Street, city, town, state) <u>Bel Air, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>June 22/55</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Run Methodist</u>	LOCATION (City, town, or county) (State) <u>Harford Md</u>
24. REC'D BY REGISTRAR <u>Prinella Lowood</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u>	ADDRESS <u>Bel Air, Md</u>
DATE <u>6-21-55</u>			

# DEATH CERTIFICATE

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>M</i>	RACE <i>W</i>
DATE OF DEATH <i>June 23, 1955</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>	Cause of Death <i>Heart Disease</i>
MANNER OF DEATH <i>Natural</i>		EDUCATION <i>High School</i>	RELIGION <i>Catholic</i>	Marital Status <i>Married</i>
Occupation <i>Teacher</i>		Place of Birth <i>Baltimore, Md.</i>	Usual Residence <i>123 Main St.</i>	Signature of Physician <i>[Signature]</i>
Signature of Registrar <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>		

NOTIFICATION

TO THE DISTRICT ATTORNEY, BALTIMORE, MARYLAND  
I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health, Baltimore, Maryland, this 23rd day of June, 1955.

STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND

BUREAU V. S.

JUN 23 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5643

## CERTIFICATE OF DEATH

05638

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>Dublin</u>		<u>30 yrs</u>		TOWN <u>Dublin</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				/			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>GEORGE</u> (Middle) <u>THOMAS</u> (Last) <u>CRESWELL</u>				June 18 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Wh	Widowed	Nov. 28, 1864	90 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farming				Harford Co., Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Creswell				Sarah Sadler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mrs Charlotte Brokenmyr, Darlington, Md.			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Ac. Coronary Occlusion, terminating a</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr Hypertensive Cardio-vascular Disease</u>						Sudden	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arterio-sclerosis</u>						---10 yrs.	
						?	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1</u> , 1942, to <u>June 18</u> , 1955, that I last saw the deceased alive on <u>June 17</u> , 1955, and that death occurred at <u>6:00a.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Willard P. Hudson</u>				M.D. 6 Rock Spring Rd. Forest Hill, Md. 6-18-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 20, 1955		Darlington		Darlington, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>0-22-55</u>		<u>Russella Lowrod</u>		<u>John H. Harkins</u>		Delta, Pa.	

# CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

SPONTANEOUS

BUREAU V. S.

JUN 27 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5644

## CERTIFICATE OF DEATH

05639

182

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		X	
TOWN				STREET ADDRESS (If rural give location) <u>Edgewood Rd.</u>		1	
71 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>							
3. NAME OF DECEASED (Type or Print) <u>Isabelle Vane Denbow</u>				4. DATE OF DEATH <u>June 16</u> 19 <u>55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. <del>SINGLE</del> , MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan 23 1890</u>	
				9. AGE last birthday <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Fallston Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jason Smithson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Duff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Katherine Litchfield Edgewood</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						17 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Atherosclerosis</u>						2 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Hypertensive C.V. Disease</u>						5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>54</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>55</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Ralph Horby</u> M.D.				ADDRESS (Street, city, town, state) <u>Churchville Md</u>		DATE SIGNED <u>June 16</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 19 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel Methodist</u>		LOCATION (City, town, or county) (State) <u>Joppa Harford Md</u>	
24. REC'D BY REGISTRAR DATE <u>6-19-55</u>		REGISTRAR'S SIGNATURE <u>Pussilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W H Archer</u>		ADDRESS <u>Benson Md</u>	



ENCLOSURE

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE ATTORNEY GENERAL, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING. IT IS TO BE KEPT IN THE OFFICE OF THE ATTORNEY GENERAL, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING. IT IS TO BE KEPT IN THE OFFICE OF THE ATTORNEY GENERAL, BALTIMORE, MARYLAND, FOR THE PURPOSE OF RECORDING AND INDEXING.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Div. No.

1. PLACE OF DEATH

2. COUNTY

3. CITY

4. STREET

5. APARTMENT NO.

6. ROOM NO.

7. BUILDING NO.

8. DISTRICT

9. ZIP CODE

10. DECEASED'S NAME

11. SEX

12. AGE

13. DATE OF BIRTH

14. PLACE OF BIRTH

15. OCCUPATION

16. CAUSE OF DEATH

17. MANNER OF DEATH

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CLERK

20. SIGNATURE OF WITNESSES

21. SIGNATURE OF DECEASED

22. SIGNATURE OF SURVIVORS

23. SIGNATURE OF OTHERS

24. SIGNATURE OF OTHERS

25. SIGNATURE OF OTHERS

26. SIGNATURE OF OTHERS

27. SIGNATURE OF OTHERS

28. SIGNATURE OF OTHERS

29. SIGNATURE OF OTHERS

BUREAU V. S.

JUN 20 1955

RECEIVED



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5645  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05640

Reg. Dist.

No. 185

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN	LENGTH OF STAY (in this place) <u>4 Hrs.</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Fullerton</u>	<u>03 X-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>		STREET ADDRESS (If rural, give location) <u>4260 Chapel Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>LAWRENCE</u>	(Middle) <u>CONRAD</u>	(Last) <u>DIETZ</u>	(Month) <u>June</u> (Day) <u>16</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Singel</u>	8. DATE OF BIRTH: <u>March 12th 1927</u>
9. AGE last birthday: <u>28</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Clerk</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Dietz</u>		14. MOTHER'S MAIDEN NAME: <u>Caroline O. Roeder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>4</u>	
17. INFORMANT & ADDRESS: <u>Mr. William Dietz Sr. 4260 Chapel Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
850X Immediate cause (a) <u>Drowning</u> DUE TO		<u>Instant</u>	
Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg, etc., INJURY <u>Boat capsized in river 1/2 mile north of Rock Run, Harford Md.</u>	21c. (City or town) (County) <u>Harford</u>	
21d. TIME (Month) <u>June</u> (Year) <u>1955</u> (Hour) <u>6 P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Boat capsized in river</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Philip W. Neuman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 16, 1955</u> M. D. <u>Acting</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>6/17/55</u>	NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>June 22-55</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis m-d</u>	24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd. #6</u>	

BUREAU V. 8

JUN 24 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05641

5648

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Harford</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Street</i>				TOWN <i>Street</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>Rural</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>(First) (Middle) (Last)</i> <i>Dallie S. Edwards</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>June 16 19 55</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 25 1901</i>	9. AGE last birthday <i>53</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework at Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Allegany Co., W. Va.</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Shephard</i>				14. MOTHER'S MAIDEN NAME <i>Hattie M. Varney</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>213-26-0273</i>		17. INFORMANT & ADDRESS <i>Emmatt Edwards Street, Md. Rural</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
199.1 IMMEDIATE CAUSE (A) <i>Euremia</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cancer in jejunum</i>				<i>2 yrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 15 1955</i> to <i>June 16 1955</i> , that I last saw the deceased alive on <i>June 15 1955</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>F.P. Snodgrass M.D.</i>				ADDRESS (Street, city, town, state) <i>Dareington Md</i> DATE SIGNED <i>6/16/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>June 18 1955</i>		<i>Beth Air Memorial Park</i>		<i>Harford Co., Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>June 17 1955</i>		<i>C. K. Kirk</i>		<i>H. S. Bailey</i>		<i>Allegany Md</i>	

# CERTIFICATE OF DEATH

Reg. - District

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF COURT

22. SIGNATURE OF STATE

23. SIGNATURE OF NATION

24. SIGNATURE OF WORLD

25. SIGNATURE OF UNIVERSE

26. SIGNATURE OF GOD

27. SIGNATURE OF DEVIL

28. SIGNATURE OF ANGELS

29. SIGNATURE OF DEMONS

30. SIGNATURE OF SPIRITS

31. SIGNATURE OF SOULS

32. SIGNATURE OF BODIES

33. SIGNATURE OF MINDS

34. SIGNATURE OF HEARTS

35. SIGNATURE OF LIVERS

36. SIGNATURE OF STOMACHS

37. SIGNATURE OF LUNGS

38. SIGNATURE OF KIDNEYS

39. SIGNATURE OF SPLEENS

40. SIGNATURE OF PANCREASES

41. SIGNATURE OF GALLBLADDER

42. SIGNATURE OF BILDS

43. SIGNATURE OF BLADDER

44. SIGNATURE OF UTERUS

45. SIGNATURE OF VAGINA

46. SIGNATURE OF CERVIX

47. SIGNATURE OF VULVA

48. SIGNATURE OF CLITORIS

49. SIGNATURE OF PENIS

50. SIGNATURE OF TESTES

51. SIGNATURE OF EPIDIDYMIS

52. SIGNATURE OF SEMEN

53. SIGNATURE OF URINE

54. SIGNATURE OF SWEAT

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57. SIGNATURE OF SPIT

58. SIGNATURE OF MUCUS

59. SIGNATURE OF PHLEGM

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62. SIGNATURE OF CRUMBS

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81. SIGNATURE OF THROAT

82. SIGNATURE OF LARYNX

83. SIGNATURE OF TRACHEA

84. SIGNATURE OF BRONCHI

85. SIGNATURE OF LUNGS

86. SIGNATURE OF HEART

87. SIGNATURE OF BLOOD

88. SIGNATURE OF PULSE

89. SIGNATURE OF TEMPERATURE

90. SIGNATURE OF PRESSURE

91. SIGNATURE OF WEIGHT

92. SIGNATURE OF HEIGHT

93. SIGNATURE OF AGE

94. SIGNATURE OF SEX

95. SIGNATURE OF OCCUPATION

96. SIGNATURE OF PLACE OF BIRTH

97. SIGNATURE OF DATE OF DEATH

98. SIGNATURE OF TIME OF DEATH

99. SIGNATURE OF CAUSE OF DEATH

100. SIGNATURE OF MANNER OF DEATH

101. SIGNATURE OF PLACE OF DEATH

102. SIGNATURE OF SIGNATURE OF PHYSICIAN

103. SIGNATURE OF SIGNATURE OF REGISTRAR

104. SIGNATURE OF SIGNATURE OF WITNESSES

105. SIGNATURE OF SIGNATURE OF DECEASED

106. SIGNATURE OF SIGNATURE OF NEXT OF KIN

107. SIGNATURE OF SIGNATURE OF CLERGYMAN

108. SIGNATURE OF SIGNATURE OF JUDGE

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110. SIGNATURE OF SIGNATURE OF CORONER

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112. SIGNATURE OF SIGNATURE OF COURT

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173. SIGNATURE OF SIGNATURE OF LARYNX

174. SIGNATURE OF SIGNATURE OF TRACHEA

175. SIGNATURE OF SIGNATURE OF BRONCHI

176. SIGNATURE OF SIGNATURE OF LUNGS

177. SIGNATURE OF SIGNATURE OF HEART

178. SIGNATURE OF SIGNATURE OF BLOOD

179. SIGNATURE OF SIGNATURE OF PULSE

180. SIGNATURE OF SIGNATURE OF TEMPERATURE

181. SIGNATURE OF SIGNATURE OF PRESSURE

182. SIGNATURE OF SIGNATURE OF WEIGHT

183. SIGNATURE OF SIGNATURE OF HEIGHT

184. SIGNATURE OF SIGNATURE OF AGE

185. SIGNATURE OF SIGNATURE OF SEX

186. SIGNATURE OF SIGNATURE OF OCCUPATION

187. SIGNATURE OF SIGNATURE OF PLACE OF BIRTH

188. SIGNATURE OF SIGNATURE OF DATE OF DEATH

189. SIGNATURE OF SIGNATURE OF TIME OF DEATH

190. SIGNATURE OF SIGNATURE OF CAUSE OF DEATH

191. SIGNATURE OF SIGNATURE OF MANNER OF DEATH

192. SIGNATURE OF SIGNATURE OF PLACE OF DEATH

193. SIGNATURE OF SIGNATURE OF SIGNATURE OF PHYSICIAN

194. SIGNATURE OF SIGNATURE OF SIGNATURE OF REGISTRAR

195. SIGNATURE OF SIGNATURE OF SIGNATURE OF WITNESSES

196. SIGNATURE OF SIGNATURE OF SIGNATURE OF DECEASED

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198. SIGNATURE OF SIGNATURE OF SIGNATURE OF CLERGYMAN

199. SIGNATURE OF SIGNATURE OF SIGNATURE OF JUDGE

200. SIGNATURE OF SIGNATURE OF SIGNATURE OF SHERIFF

201. SIGNATURE OF SIGNATURE OF SIGNATURE OF CORONER

202. SIGNATURE OF SIGNATURE OF SIGNATURE OF JURY

203. SIGNATURE OF SIGNATURE OF SIGNATURE OF COURT

204. SIGNATURE OF SIGNATURE OF SIGNATURE OF STATE

205. SIGNATURE OF SIGNATURE OF SIGNATURE OF NATION

206. SIGNATURE OF SIGNATURE OF SIGNATURE OF WORLD

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211. SIGNATURE OF SIGNATURE OF SIGNATURE OF DEMONS

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213. SIGNATURE OF SIGNATURE OF SIGNATURE OF SOULS

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215. SIGNATURE OF SIGNATURE OF SIGNATURE OF MINDS

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217. SIGNATURE OF SIGNATURE OF SIGNATURE OF LIVERS

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221. SIGNATURE OF SIGNATURE OF SIGNATURE OF SPLEENS

222. SIGNATURE OF SIGNATURE OF SIGNATURE OF PANCREASES

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238. SIGNATURE OF SIGNATURE OF SIGNATURE OF SALIVA

239. SIGNATURE OF SIGNATURE OF SIGNATURE OF SPIT

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242. SIGNATURE OF SIGNATURE OF SIGNATURE OF SPUTUM

243. SIGNATURE OF SIGNATURE OF SIGNATURE OF CRACKERS

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252. SIGNATURE OF SIGNATURE OF SIGNATURE OF MEAT

253. SIGNATURE OF SIGNATURE OF SIGNATURE OF FAT

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256. SIGNATURE OF SIGNATURE OF SIGNATURE OF NAILS

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258. SIGNATURE OF SIGNATURE OF SIGNATURE OF GUMS

259. SIGNATURE OF SIGNATURE OF SIGNATURE OF EYES

260. SIGNATURE OF SIGNATURE OF SIGNATURE OF EARS

261. SIGNATURE OF SIGNATURE OF SIGNATURE OF NOSE

262. SIGNATURE OF SIGNATURE OF SIGNATURE OF MOUTH

263. SIGNATURE OF SIGNATURE OF SIGNATURE OF THROAT

264. SIGNATURE OF SIGNATURE OF SIGNATURE OF LARYNX

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5624

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1-2 by Phone Dr. Fisher 6-14-55 am 1 Com 2 Film 6-17-55 am

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

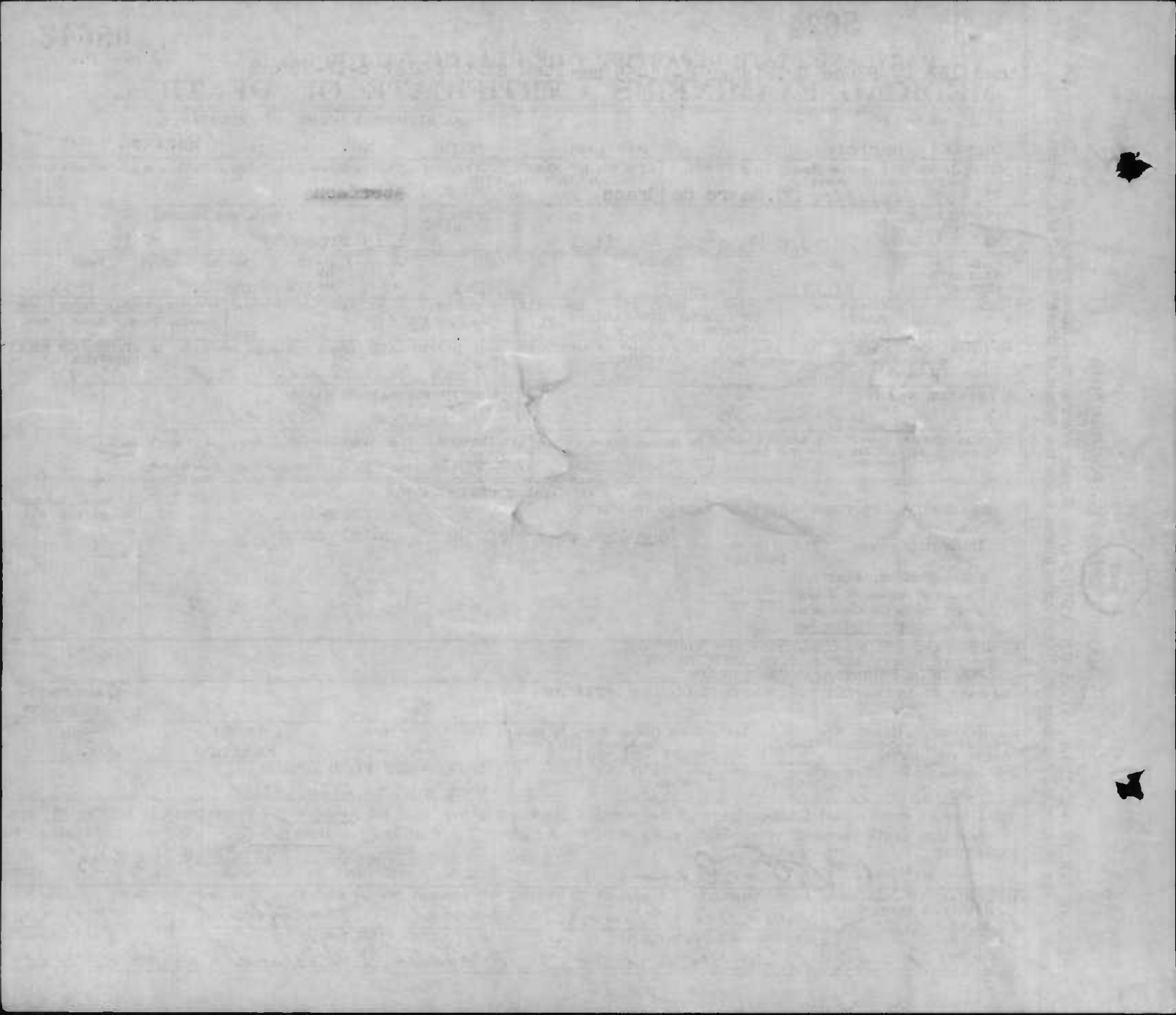
05642

Reg. Dist.

No. 185

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Harford		STATE	Md. COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
31 TOWN	Aberdeen, Md.	Grace	TOWN	Aberdeen 31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
7 Harford Memorial Hospital			1213 Broadway		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
WILLIAM	MARVIN	FLEMING	June	6,	19 55
(Type or Print)					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	Colored	Separated	Dec 19, 1933	22 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
			Roanoke Rapids N.C.		U.S.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Isaac Fleming			Laura Price		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
			Wallie H. Fleming 1914 Church St Roanoke Rapids, N.C.		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
981X Immediate cause (a) Gunshot wound of chest and abdomen					
DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause					
DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY street		21c. (City or town) (County) (State)	
				Aberdeen Harford Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY June 5, 1955		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
				Shot during altercation	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		DATE SIGNED			
B. Fisher		6/7/55			
		M. D. CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		June 12, 1955		Roanoke Rapids	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
6-55		Mrs. L. R. Williams		Halifax Co. N.C.	
		24. FUNERAL DIRECTOR		ADDRESS	
		Mrs. L. R. Williams		r. Schreder St.	





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05643

No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		X	
TOWN <i>Magnolia</i>		<i>Life</i>		TOWN <i>Magnolia</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Magnolia</i>				STREET ADDRESS (If rural, give location) <i>Magnolia</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>GEORGE</i>		(Middle) <i>W.</i>		(Last) <i>GILBERT</i>		(Month) (Day) (Year) <i>June 11 1955</i>	
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>Negro</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <i>Nov. 17, 1883</i>	
9. AGE last birthday: <i>71</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Trackman</i>		11. BIRTHPLACE (State or foreign country): <i>Magnolia, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>William Gilbert</i>				14. MOTHER'S MAIDEN NAME: <i>Martha Scott</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY No.: <i>717-07-5431</i>		17. INFORMANT & ADDRESS: <i>Mary B. Gilbert, Magnolia, Maryland.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <i>Coronary Occlusion</i>						<i>Instant</i>	
Antecedent cause(s) (b) <i>Arterio-sclerosis, senility</i>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>Philip W. Thompson</i>		CHIEF MEDICAL EXAMINER <i>act</i>		DEPUTY MEDICAL EXAMINER		DATE SIGNED <i>June 11, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>June 15, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>John Wesley</i>		LOCATION (City, town, or county) (State) <i>Magnolia, Harford, Md.</i>	
DATE REC'D BY LOCAL REG. <i>June 14, 1955</i>		REGISTRAR'S SIGNATURE <i>Norma E. Moore</i>		24. FUNERAL DIRECTOR <i>Howard K. McComas &amp; Son</i>		ADDRESS <i>Abingdon Md.</i>	

RECEIVED

JUN 16 1955

BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05644

5627

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

Item 7. Film G183 7-11-55 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Harford</i>		STATE <i>Maryland</i> COUNTY <i>Harford</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		LENGTH OF STAY (in this place)		OR TOWN <i>Aberdeen</i>		OR TOWN <i>Aberdeen</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>#6 Hanover Street</i>				STREET ADDRESS (If rural give location) <i>#6 Hanover Street</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Vernon</i> (Middle) <i>Robinson</i> (Last) <i>Giles</i>				(Month) <i>June</i> (Day) <i>28th</i> (Year) <i>1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb 5th 1921</i>	9. AGE last birthday <i>34</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day laborer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Auto. Garage</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Isaac F. Giles</i>				14. MOTHER'S MAIDEN NAME <i>Harriet E. Thompson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-07-4266</i>		17. INFORMANT & ADDRESS <i>Harry H. Giles Box 374 Aberdeen rd.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
443x IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <i>Hypertensive Cardiovascular disease</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan</i> , 19 <i>54</i> , to <i>July 28</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>July 27</i> , 19 <i>55</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>George J. Stansbury</i>				ADDRESS (Street, city, town, state) <i>569 Revolution St. Havre de Grace, Md.</i>		DATE SIGNED <i>7/1/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>7/1/55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cemetery</i>		LOCATION (City, town, or county) (State) <i>Aberdeen Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mellie R Perry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Tarring</i>		ADDRESS <i>Aberdeen rd.</i>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5628

## CERTIFICATE OF DEATH

05645

Reg. Dist. No. 183

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>Harre de Grace</u>		LENGTH OF STAY (In this place) <u>4 day</u>		CITY OR TOWN <u>Harre de Grace</u>		<u>24</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hosp.</u>				STREET ADDRESS (If rural give location) <u>739 Ontario St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>William Henry Heimiller</u>				<b>4. DATE OF DEATH</b> (Month) <u>June</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov. 25, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. foreman ord. Dept. A.P.G.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Heimiller</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA KERR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT & ADDRESS <u>Effie C. Heimiller, Ontario St.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>6-5</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-5</u> 19 <u>55</u> to <u>6-9</u> 19 <u>55</u> that I last saw the deceased alive on <u>6-8</u> 19 <u>55</u> and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Harre de Grace - Md.</u>		DATE SIGNED <u>June 9-1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE OF BURIAL <u>6/11/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) (State) <u>Harre de Grace Md.</u>	
24. REC'D BY REGISTRAR <u>June 11-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington Son</u>		ADDRESS <u>Harre de Grace Md.</u>	

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

MARYLAND

2. DATE OF DEATH

Nov. 25, 1988

3

4

• Illness

5. SIGNATURE OF REGISTRAR

BUREAU V. S.

JUN 14 1988

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased during the illness or at the time of death. It should be filled out as soon as possible after death, but not later than 72 hours after death. It should be signed by the physician or other person who has attended the deceased during the illness or at the time of death. It should be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It should be kept for a period of 10 years.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05646

5648

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin RD</u> OR TOWN <u>5 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>08</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin RD</u> OR TOWN <u>1</u> STREET ADDRESS (If rural give location) <u>upper Cross Roads</u>			
3. NAME OF DECEASED (First) <u>MYRTLE</u> (Middle) <u>Gray</u> (Last) <u>HENDERSON</u>			4. DATE OF DEATH (Month) <u>June</u> (Day) <u>27</u> (Year) <u>19 55</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Oct 30, 1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Fallston Md</u>			
13. FATHER'S NAME <u>Carvill Amoss</u>			14. MOTHER'S MAIDEN NAME <u>Laura Spencer</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Lula Mummitchy on</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Acute Lobar Pneumonia, terminating</u>					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs?</u>		
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u> (B) <u>Cerebral Thrombosis with Hemiplegia (left)</u>					<u>4 mos</u>		
(C) <u>Chr. Cardio-vascular disease with hypertension &amp;</u>					<u>8 yrs.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u> <u>Chr Arthritis of Spine</u>					<u>6 yrs</u>		
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>45</u> , to <u>June 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>55</u> , and that death occurred at <u>2:35 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hedson</u> M.D. Forest Hill, Md.			DATE SIGNED <u>6-28-55</u>				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 30 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>			
24. REC'D BY REGISTRAR <u>7-6-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u> ADDRESS <u>Benson Md</u>			



5629

05647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 182

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Bell Air</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Bell Air</i>	32
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>902 William St.</i>		STREET ADDRESS (If rural, give location)	<i>902 William St.</i>
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <i>SAMUEL ALFRED JACKSON</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>June 15 19 55</i>	
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>Ch</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>W</i>	8. DATE OF BIRTH: <i>MARCH 31, 1891 64</i>
9. AGE last birthday: <i>64</i>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>laborer</i>	
11. BIRTHPLACE (State or foreign country): <i>Joppe Harford, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>Alford Johnson</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Dorsey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>3 No</i>		16. SOCIAL SECURITY No.: <i>196-18-6669</i>	
17. INFORMANT & ADDRESS: <i>Mary Dorsey Jackson Bell Air, MD</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i>	
(a) Immediate cause <i>420.1</i>			
(b) Antecedent cause(s) <i>Coronary Occlusion</i>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <i>Arteriosclerosis</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Philip W. Newman</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>June 16-55</i>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>June 19/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Mountain Methodist</i>		LOCATION (City, town, or county) (State) <i>Wilks Harford Co MD</i>	
DATE REC'D BY LOCAL REG. <i>6-17-55</i>		REGISTRAR'S SIGNATURE <i>Muriella Lowood</i>	
		24. FUNERAL DIRECTOR <i>Joseph J. Foster Bel Air Md</i>	
		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 20 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

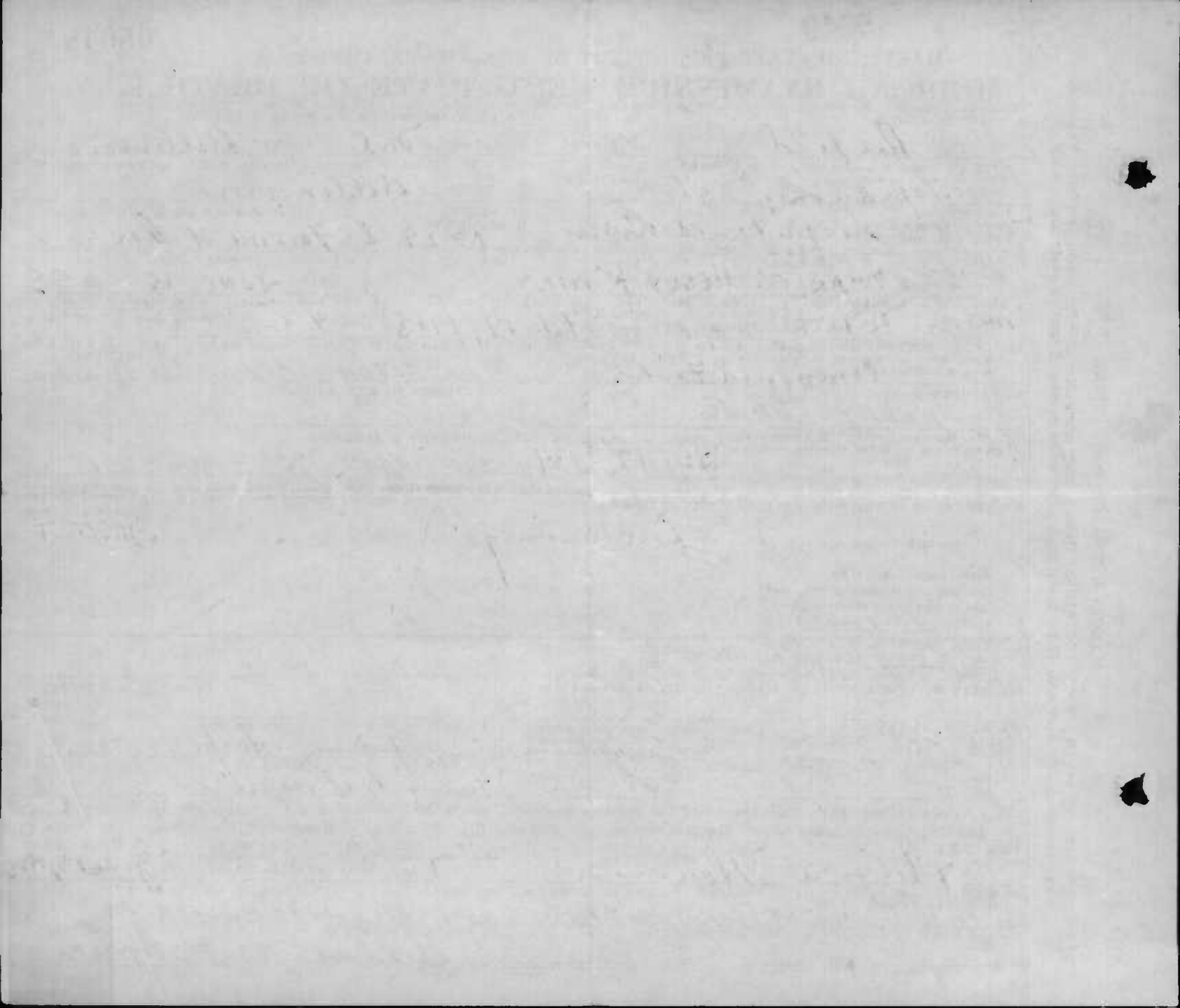
5649

05648  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lepidum, Md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Baltimore</u>		3001.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Susquehanna River</u>				STREET ADDRESS (If rural, give location) <u>1729 E. Furment Ave.</u> ✓			
3. NAME OF DECEASED: (Type or Print) <u>CHARLES HENRY KUHN</u>				4. DATE OF DEATH <u>JUNE 15</u> 19 <u>55</u>			
5. SEX: <u>male</u>		6. COLOR, OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED Feb 19, 1913</u>		8. DATE OF BIRTH: <u>42</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Commercial Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>HAZELTON PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>HENRY KUHN</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>315 12 9734</u>		17. INFORMANT & ADDRESS: <u>BESSIE KUHN 1729 E FAIRMOUNT AVE</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Drowning</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Instant</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Susquehanna River, Lepidum, Harford Md</u>		21c. (City or town) (County) (State) <u>Harford Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fishing boat capsized</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Philip W. Neuman</u>		CHIEF MEDICAL EXAMINER <u>Acting</u>		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>June 15, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>JUNE 16 1955</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM</u>		LOCATION (City, town, or County) (State) <u>4430 BELAIR RD MD.</u>	
DATE REC'D BY LOCAL REG. <u>6-16-55</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>Duffel Bros</u>		ADDRESS <u>1800 E LOMBARD ST</u>	





1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5630

## CERTIFICATE OF DEATH

05649

Reg. Dist. No. 185-

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		STATE <u>MARYLAND</u>		CITY <u>HARFORD</u>		COUNTY <u>HARFORD</u>	
CITY OR TOWN <u>HARFORD</u>		LENGTH OF STAY (in this place) <u>13 days</u>		CITY OR TOWN <u>STREET</u>		STREET ADDRESS <u>R.D. #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEM. HOSP.</u>							
3. NAME OF DECEASED (Type or Print) <u>Frederick H. Leftwich</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>2.24.01</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rubin Leftwich</u>				14. MOTHER'S MAIDEN NAME <u>SARAH PUCKET</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY NO. <u>220-22-0142</u>		17. INFORMANT & ADDRESS <u>Nell Leftwich - wife</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>593 X</u>							
IMMEDIATE CAUSE (A) <u>Uremia</u>				48 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Septicemia</u>				4 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Glomerulo nephritis</u>				3 months			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 23, 1955</u> to <u>June 4, 1955</u> , that I last saw the deceased alive on <u>June 3, 1955</u> , and that death occurred at <u>10:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M.C. Finney</u>				DATE SIGNED <u>June 6-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				ADDRESS (Street, city, town, state) <u>Aboudeen, Maryland</u>			
DATE THEREOF <u>June 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cn</u>		LOCATION (City, town, or county) <u>HARFORD CO MD</u>		(State) <u></u>	
24. REC'D BY REGISTRAR <u>June 8-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Parlinton</u>	

# CERTIFICATE OF DEATH

Form No. 10-1-1954

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

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BUREAU V. S.

JUN 9 1955

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF SOCIAL SERVICES. IT IS THE POLICY OF THE MARYLAND DEPARTMENT OF HEALTH TO MAINTAIN THE INTEGRITY OF THIS CERTIFICATE AND TO PREVENT ITS USE FOR ANY OTHER PURPOSE. ANY ATTEMPT TO USE THIS CERTIFICATE FOR ANY OTHER PURPOSE WILL BE CONSIDERED A VIOLATION OF THE MARYLAND DEPARTMENT OF HEALTH'S POLICY AND WILL BE PUNISHED ACCORDINGLY.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5631

## CERTIFICATE OF DEATH

05650

Reg. Dist. No. 186

1. PLACE OF DEATH COUNTY <i>Harford</i> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> 24 <i>Harford Grace</i> 3mt.		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> 24 STREET ADDRESS (If rural, give location) <i>310 N. Stokes</i>	
3. NAME OF DECEASED (Type or Print) <i>Robert Edward Lloyd</i> (First) (Middle) (Last)		4. DATE OF DEATH <i>6/27/55</i> (Month) (Day) (Year)	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M.</i>	8. DATE OF BIRTH <i>Aug 1-1881</i>
9. AGE last birthday <i>73</i> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>County Road</i>	
11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward L. Lloyd</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>None</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT & ADDRESS <i>Robert L. Lloyd Harford Grace</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
153X IMMEDIATE CAUSE (A) <i>auricular fibrillation</i>		<i>14 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma of ascending colon</i>		<i>6 weeks</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Carcinoma of liver</i>		<i>6 weeks</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none</i>			
19a. DATE OF OPERATION <i>6-18-55</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of abdominal wall node (Biopsy)</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5-25</i> , 19 <i>55</i> , to <i>6-27</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>6-27</i> , 19 <i>55</i> , and that death occurred at <i>11:00</i> A.M. from the causes and on the date stated above.			
SIGNATURE <i>Joseph R. Dolce</i>		ADDRESS (Street, city, town, state) <i>421 Congress Ave., Harford Grace, Md.</i> DATE SIGNED <i>6/28/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6/30/55</i> NAME OF CEMETERY OR CREMATORY <i>Harford Grace</i> LOCATION (City, town, or county) <i>Harford Co.</i>	
24. REC'D BY REGISTRAR <i>June 29-1955</i>		REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i> 25. FUNERAL DIRECTOR'S SIGNATURE <i>Harford Grace, Md.</i> ADDRESS	

CERTIFICATE OF DEATH

NAME OF DECEASED

MARYLAND

COUNTY OF

CITY OF

STATE OF

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

TEMPORARY CAUSE

ACUTE CAUSE

CHRONIC CAUSE

INFECTIOUS CAUSE

NON-INFECTIOUS CAUSE

TRAUMATIC CAUSE

TOXIC CAUSE

CONSTITUTIONAL CAUSE

HEREDITARY CAUSE

ACQUIRED CAUSE

DEGENERATIVE CAUSE

NEURAL CAUSE

MUSCULAR CAUSE

ARTHRITIC CAUSE

OSTEOARTHRITIC CAUSE

ARTHRITIS CAUSE

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BUREAU V. 8

JUN 30 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5650

## CERTIFICATE OF DEATH

05651

Reg. Dist. No. 181

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> (see birth cert.)			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland Conn.</u> COUNTY <u>Harford</u> <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen Proving Gd.</u>		<u>3 days</u>		TOWN <u>Edgewood Enfield</u>		<u>45X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>24-D McCann Street 22 Roy Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Elizabeth</u>		(Middle) <u>Ann</u>		(Last) <u>Loomis</u>		(Month) <u>June</u> (Day) <u>2</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>30 May 1955</u>		9. AGE last birthday yrs. <u>3</u>		IF UNDER 1 YEAR (Month) <u>3</u> (Day) <u>3</u> (Hours) <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Raymond Hugh Loomis</u>				14. MOTHER'S MAIDEN NAME <u>Jean Elizabeth Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, 24-D McCann St Edgewood, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Atalectasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Pres. at Birth</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hyaline Membrane</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>30 May</u> , 19 <u>55</u> , to <u>2 June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2 June</u> , 1955, and that death occurred at <u>4:30P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert D. Hume</u>				DATE SIGNED <u>2 June 1955</u>			
ROBERT D. HUME, Major, MC				M.D. US Army Hospital, APG, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>6/4/55</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Cemetery</u>		LOCATION (City, town, or county) (State) <u>Armed Services Center Md</u>	
24. REC'D BY REGISTRAR <u>Nellie R. Perry</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarrington</u>		ADDRESS <u>Chesden Md</u>	
DATE <u>June 4-55</u>		<u>2055261374</u>					







5651

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

COUNTY **HARFORD**

MARYLAND

CITY (If outside corporate limits, write RURAL or and give nearest town)

X TOWN **RURAL - BELAIR**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTE OR STREET ADDRESS

U.S. ROUTE #1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD.**COUNTY **HARFORD**

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET

STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

**EVELYN BELLE MCBRIDE**

## 4. DATE (Month) (Day) (Year)

OF

DEATH: **JUNE 24, 1955**

## 5. SEX:

**F**

## 6. COLOR OR RACE:

**W**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

**WIDOWED**

## 8. DATE OF BIRTH:

**OCT. 7, 1881**

## 9. AGE last birthday

**73** yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

Months

Days

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

**HOUSEWIFE**

## 10B. KIND OF BUSINESS OR INDUSTRY:

**—**

## 11. BIRTHPLACE (State or foreign country):

**STREET, MD.**

## 12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

## 13. FATHER'S NAME:

**PARKER F. SCARBOROUGH**

## 14. MOTHER'S MAIDEN NAME:

**BELLE V. HEAPS**

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**No**

## 16. SOCIAL SECURITY NO.

**—**

## 17. INFORMANT &amp; ADDRESS:

**MRS. JAMES HEAPS, STREET, MD.**

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**420.1**

## IMMEDIATE CAUSE

(A)

DUE TO

**coronary thrombosis**

## ANTECEDENT CAUSE (S)

(B)

DUE TO

**coronary sclerosis**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## INTERVAL BETWEEN ONSET AND DEATH

**5 years**

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 1950, to June 24, 1955, that I last saw the deceased

alive on June 24, 1955, and that death occurred at 7:30 M, from the causes and on the date stated above.

SIGNATURE

**John Harkins**

M. D.

ADDRESS

**1414 Duff**

DATE SIGNED

**June 27, 1955**

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

**BURIAL****6-27-55****HIGHLAND****STREET, MD.**

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

**7/28/55****Priscilla Howard****JOHN H. HARKINS, DELTA, PA.**

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 30 1965

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS ATSC 1-55 10M

5632

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (in this place) <u>2.4</u>		CITY OR TOWN <u>Harford</u>		CITY OR TOWN <u>2.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural give location) <u>Bel Air Road</u>		STREET ADDRESS		STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth W. H. PERRY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>6/26/55</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>1/15/1874</u>	
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr. Wm. W. Hopkins</u>				14. MOTHER'S MAIDEN NAME <u>Isabella L. Dover</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Mrs. John Marshall, Silver Col.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.0 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1951</u> , to <u>6-26-55</u> , that I last saw the deceased alive on <u>6-24-55</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. W. Hopkins, M.D.</u>		DATE SIGNED <u>6-26-55</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Washington</u>		LOCATION (City, town, or county) (State) <u>Washington, Md.</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>June 29-1955</u>		<u>H. L. Lewis, M.D.</u>		<u>Harford, Md.</u>		<u>Harford, Md.</u>	

# CERTIFICATE OF DEATH

1. DEATH RESIDENCE (HOME OR PLACE)

2. PLACE OF DEATH

MARYLAND

3. DATE OF DEATH

4. TIME OF DEATH

5. MEDICAL CERTIFICATION

6. SIGNATURE OF PHYSICIAN

BUREAU V. 1

JUN 30 1955

RECEIVED

SMITHSONIAN INSTITUTION

RECEIVED  
JUN 30 1955  
BUREAU V. 1

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05653

5633

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Har-de-Grace</u>		<u>1 day</u>		TOWN <u>Aberdeen</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>3 Hanover ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Helen G. Porter</u>				<u>June 11 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>May 17, 1908</u>	<u>47</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Texas</u>		<u>U.S.G.</u>	
13. FATHER'S NAME <u>Jesse Clarey</u>				14. MOTHER'S MAIDEN NAME <u>Sally Ware</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>456-34-2882</u>		<u>Robert Porter, Husband</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
260X IMMEDIATE CAUSE (A) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Diabetic Coma</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/9</u> , 19 <u>55</u> to <u>6/11</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>6/11</u> , 19 <u>55</u> ; and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles J. Kelly</u> M.D.				ADDRESS (Street, city, town, state) <u>Har-de-Grace Md</u> DATE SIGNED <u>6/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>	<u>6/15/55</u>	<u>Lot Calvary Cemetery</u>		<u>Aberdeen, Maryland</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE				
<u>June 15-55</u>	<u>G. L. Lewis M.D.</u>		<u>John G. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>				

CERTIFICATE OF DEATH

1. USUAL RESIDENCE: HOUSE OF DECEASED

2. PLACE OF DEATH

DECEASED

DATE

DATE

DATE

*Residence of Deceased*  
*Residence of Deceased*

BUREAU V. 8

JUN 18 1955

RECEIVED

INSTRUCTIONS



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5634

## CERTIFICATE OF DEATH

05655

Reg. Dist. No. 185

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harre de Grace</u>		LENGTH OF STAY (in this place) <u>26 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		TOWN <u>x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hosp.</u>				STREET ADDRESS (If rural give location) <u>RFD#1 Box 176</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lloyd</u> (First) <u>Presbury</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>6</u> (Day) <u>8</u> (Year) <u>1955</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>about 1872</u>	9. AGE last birthday <u>about 83 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Presbury</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Christy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Harford Co. Harford Board - Bel-Air, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
177X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastatic Carcinoma of Prostate</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Heart disease</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/10</u> , 19 <u>53</u> , to <u>6/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/8</u> , 19 <u>55</u> , and that death occurred at <u>1:55 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George J. Stansbury</u> M.D. <u>569 Revolution St. Harre de Grace Md.</u>				DATE SIGNED <u>5/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Gravel Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>	
24. REC'D BY REGISTRAR <u>June 11-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otilis J. Bullock</u>		ADDRESS <u>Harre de Grace Md.</u>	



**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5635

## CERTIFICATE OF DEATH

Reg. Dist. No. 05656 85-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
24 TOWN <u>Harford &amp; Grace</u>		34 days		HARFORD TOWN <u>Harford &amp; Grace</u>		24	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <u>Harford Memorial Hosp</u>				110 S Washington ST.			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>HARRY</u> (Middle) <u>S</u> (Last) <u>PRESTON</u>				(Month) <u>June</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	MARRIED	Oct. 30-1884	70 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Self Emp Carpenter</u>		<u>Carpentering</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Preston</u>				<u>Laura Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk. g</u> (If Yes, give war or dates of service)		217-05-7826		<u>Wm Harry S. Preston</u> <u>110 S. West St. Harford &amp; Grace</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
260X IMMEDIATE CAUSE (A)				<u>Diabetes Mellitus</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Diabetes Coma</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Anorexia</u>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
<u>0</u>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>January 1, 1955</u> , <b>to</b> <u>June 24, 1955</u> , <b>that I last saw the deceased alive on</b> <u>January 1, 1955</u> , <b>and that death occurred at</b> <u>2:03 P.M.</u> <b>from the causes and on the date stated above.</b>							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Charles J. Jolly</u>		<u>400 Wm Harford &amp; Grace</u>		<u>6/24</u>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/28/55</u>		<u>Wesley Chapel Cemetery</u>		<u>Aberdeen R.T. Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 28-55</u>		<u>G. L. Lewis M.D.</u>		<u>John G. Carney</u>		<u>Aberdeen Md.</u>	
DATE							



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5636

## CERTIFICATE OF DEATH

05657

Reg. Dist. No. 183-

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY OR TOWN <u>HAORE DE GRACE</u>		LENGTH OF STAY (in this place) <u>30 DAYS</u>		CITY OR TOWN <u>ABERDEEN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp</u>				STREET ADDRESS <u>R.D. #2</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>William GARTYER PRICE</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>JUNE 26 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>July 15 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Emp farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William D PRICE</u>		14. MOTHER'S MAIDEN NAME <u>Ellen McIntosh</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-07-4270</u>		17. INFORMANT & ADDRESS <u>Owner Wm. Price Balto 31. ind.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
199.9 IMMEDIATE CAUSE (A) <u>Abdominal Carcinomatosis</u>				<u>(Primary site not determined)</u>		<u>1 yr.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>6-1-55</u> <b>to</b> <u>6-26-55</u> <b>that I last saw the deceased</b> <b>alive on</b> <u>6-26-55</u> <b>and that death occurred at</b> <u>12:00 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>John W. Bodman</u> <b>M.D.</b> <u>Abderden Md.</u> <b>DATE SIGNED</b> <u>6-26-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Wesleyan Chapel cemetery</u>		LOCATION (City, town, or county) (State) <u>Abderden R.D. #1 Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lewis m.d.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarnay</u>		ADDRESS <u>Abderden Md.</u>	
DATE <u>June 28-55</u>							



BUREAU V. S.

JUN 29 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5637				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		05658.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....							
1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Baltimore</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> 31014			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u>				STREET ADDRESS (If rural, give location) <u>2102 E. Jefferson</u> ✓			
3. NAME OF DECEASED: (Type or Print)		(First) <u>JAMES</u>		(Middle) <u>S</u>		(Last) <u>SLIVECKY</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>Dec. 16, 1920</u>	
9. AGE last birthday: <u>34</u> yrs.		(Month) <u>16</u> (Day) <u>13</u> (Year) <u>1955</u>		9. AGE last birthday: <u>34</u> yrs.		10. DATE OF DEATH <u>16 13 1955</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Mounter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>New City Optical Co</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Slivecky</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Hudacek</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>Army #2</u>		16. SOCIAL SECURITY No.: <u>220-09-6341</u>		17. INFORMANT & ADDRESS: <u>Albert Slivecky, brother, 156 N. Luzerne Ave.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
825X Immediate cause (a) <u>Fractured skull: abrasion of</u>							
Antecedent cause(s) (b) <u>Rt elbow &amp; shoulder &amp; knee - Lacerated forehead &amp; scalp.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Compton Beach Md.</u>		21d. TIME (Month) (Day) (Year) OF INJURY <u>6 13 55</u>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile Collision</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. L. Peterson</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>6-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>June 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-15-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>2601-3-5 E. Madison St.</u>	

1947  
JUNE 10, 1947  
NEW YORK, N.Y.

TO THE  
DIRECTOR  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

FROM  
JOHN J. CONNELLEY  
NEW YORK, N.Y.

SUBJECT  
JOHN J. CONNELLEY  
NEW YORK, N.Y.

RE  
NEW YORK, N.Y.

1947  
JUNE 10, 1947  
NEW YORK, N.Y.

5633

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

125 (1/5/54)

No. 185

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Harford</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Harford</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Harford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>105 W. Garfield Drive</u>	
3. NAME OF DECEASED: (Type or Print) <u>MELINDA V. SMITH</u>		4. DATE OF DEATH <u>June 16 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 1, 1914</u>
9. AGE last birthday: <u>41</u> yrs.		10. DATE OF BIRTH: <u>Jan. 1, 1914</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>nurses aid</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>V.A. Hospital</u>	
11. BIRTHPLACE (State or foreign country): <u>Calington, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Walter H. Garrison</u>		14. MOTHER'S MAIDEN NAME: <u>Ethel Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>098-14-1101</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Mrs. William Smith - Harford Drive</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
420.1 Immediate cause (a) <u>myocardial infarction</u>	DUE TO	<u>20 min</u>
Antecedent cause(s) (b) <u>Cardiac Arrest during anesthesia</u>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Arrested Syphilis</u>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>16 June</u>	19b. MAJOR FINDING OF OPERATION: <u>uterine myomata, Hydrosalpinx, Endometriosis</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Philip W. Newman CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 17 June 1955  
 M.D. acting DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6-20-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Asbury Cemetery</u>	LOCATION (City, town, or county) (State): <u>Churchville, Harford Co. Md.</u>
DATE REC'D BY LOCAL REG: <u>June 18-1955</u>	REGISTRAR'S SIGNATURE: <u>A. L. Lewis m.d.</u>	24. FUNERAL DIRECTOR: <u>Charles J. Bullock, Harford Drive, Md.</u>	

RECEIVED

JUN 20 1955

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05660

5652

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Harford County</u> MARYLAND	CITY OR TOWN <u>Garrettsville</u>	STATE <u>Maryland</u> COUNTY <u>Harford</u>	CITY OR TOWN <u>Garrettsville, Md.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>		STREET ADDRESS (if rural give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Jesse</u> (Middle) <u>Clinton</u> (Last) <u>Taylor</u>		(Month) <u>June</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 20, 1857</u>
9. AGE last birthday <u>97</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>29</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>Monument Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>York Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Anthony K. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Julia Rutledge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Mr. Charles H Taylor 108 Montrose Catonsville</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
442 IMMEDIATE CAUSE (A) <u>Renal failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic cardio</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>vascular renal disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <u>June 20</u>		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20d. HOW DID INJURY OCCUR?	
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21b. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
22. I hereby certify that I attended the deceased from <u>June 18, 1955</u> to <u>June 19, 1955</u> that I last saw the deceased alive on <u>June 18, 1955</u> and that death occurred at <u>11:24 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H Taylor</u>		DATE SIGNED <u>June 19, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR	
DATE THEREOF <u>6-21-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Mount Shrub</u>		ADDRESS <u>Garrettsville, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

# CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOUSE OR BUILDING)

MARYLAND  
COUNTY OF BALTIMORE

DATE OF DEATH  
STATE

11 28 -

BUREAU V. R.

JUN 28 1955

RECEIVED

6-21-55 for certificate

Barber



1

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5653

## CERTIFICATE OF DEATH

05661

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Harford</u>	
CITY OR TOWN <u>Upper Cross Roads</u>		LENGTH OF STAY (in this place) <u>40 yrs</u>		CITY OR TOWN <u>Upper Cross Roads</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Fallston</u>			
3. NAME OF DECEASED (Type or Print) <u>Gda L Tederick</u>				4. DATE OF DEATH <u>June 26 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>		8. DATE OF BIRTH <u>Dec 16 1866</u>	
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Springs W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS <u>Mr. Trust Co</u> <u>Wm J Casey Baltimore, B.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
421.1 IMMEDIATE CAUSE (A) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 23, 1955</u> , to <u>JUNE 25, 1955</u> , that I last saw the deceased alive on <u>June 23, 1955</u> , and that death occurred at <u>2:01 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Valerie M. Hammett</u>				ADDRESS (Street, city, town, state) <u>Baltimore</u>			
DATE SIGNED <u>June 27, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>6-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>James C. - Manor Rd Balto</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Fawcett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Kertson</u>		ADDRESS <u>Lanesville md</u>	
DATE <u>6-29-55</u>							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Hawford

Upper Cross Roads Hwy

Mr. Hawford

Upper Cross Roads

Fallston

Ada L. Tedderick

June 22

Female White Single

Age 88

6 10

Housekeeper

Retired

Berkley Springs W. Va. and

Not Known

Not Known

Was 1 casey Baltimore Md

No

BUREAU V. E.

JUL 25 1955

23

June 22

*[Handwritten signatures and notes at the bottom of the page, including "JUL 25 1955" and "BUREAU V. E."]*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5639

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05662  
Reg. Dist.

No. 182

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Del</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bel Air</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Bel Air</u> 32			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>202 Thomas St.</u>				STREET ADDRESS (If rural, give location) <u>202 Thomas St</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>MARGARET ELIZABETH TOWNSLEY</u>				(Month) (Day) (Year) <u>June 12 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>FEB. 7, 1890</u>	
9. AGE last birthday: <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Nurse</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JAMES OLIVER TOWNSLEY</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE CECELIA COE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>4</u>		17. INFORMANT & ADDRESS: <u>Myrtle Townsley, 202 Thomas St, Bel Air, Del.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>Diabetes Mellitus; Hypertension</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Cardiovascular disease, Arteriosclerosis</u>						<u>Instant</u>  <u>Over 2 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bursitis, Lt shoulder, severe</u>							
19a. DATE OF OPERATION: <u>6/14/55</u>						19b. MAJOR FINDING OF OPERATION:	
19a. DATE OF OPERATION: <u>6/14/55</u>						19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) _____ (County) _____ (State) _____		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Philip W. Seaman</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>6/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>James H. Garrettville</u>		<u>June 14 1955</u>		<u>Garrettville</u>		<u>Harford, Md</u>	
DATE REC'D BY LOCAL REG. <u>6/14/55</u>		REGISTRAR'S SIGNATURE <u>W. Noella Lowwood</u>		24. FUNERAL DIRECTOR <u>Martin S. Kurtz Garrettville</u> ADDRESS <u>rec'd</u>			

BUREAU V. S.

JUN 16 1955

RECEIVED  
JUN 16 1955  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

James H. McNeill

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

5654

1. PLACE OF DEATH- COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORK</b>	
TOWN <b>FORK</b>		TOWN <b>FORK</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>WILSON ROAD</b>		STREET ADDRESS <b>WILSON ROAD</b> (If rural, give location)	
3. NAME OF DECEASED (First) <b>LAWRENCE</b> (Middle) <b>ELLSWORTH</b> (Last) <b>WOLFE</b>		4. DATE OF DEATH (Month) <b>JUNE</b> (Day) <b>4</b> (Year) <b>1955</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>MAY 30, 1910</b>	
9. AGE last birthday <b>45</b> yrs.		10. If under 1 year: Months <b>1</b> Days <b>19</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>ELECTRIC PLATING WESTERN ELECTRIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN WOLFE</b>		14. MOTHER'S MAIDEN NAME <b>ALICE SEVILLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <b>YES</b>	
17. INFORMANT <b>MRS HELEN L. WOLFE</b>		18. SAME. <b>SAME.</b>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <b>420.1</b>		(a) <b>Coronary occlusion</b>		<b>1 hr.</b>	
Antecedent cause(s)		(b)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **June 4, 1955**, to **June 4, 1955**, that I last saw the deceased alive on **June 4, 1955**, and that death occurred at **3:42** p.m., from the causes and on the date stated above.

SIGNATURE **William A. Tyson M.D.** ADDRESS **Kingsville** DATE SIGNED **June 4, 1955**

23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DATE <b>JUNE 7, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		LOCATION (City, town, or county) <b>BALTIMORE</b> (State) <b>MARYLAND</b>	
DATE REC'D BY LOCAL REG. <b>6-6-55</b>		REGISTRAR'S SIGNATURE <b>Dr. Adolph</b>		24. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS INC</b>		ADDRESS <b>BALTIMORE MARYLAND</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

